Questions from The Army MEDCOM Annual Meeting on JCAHO Issues in Chicago, Illinois, Dec 2002 Presented to 200 MTF Staff Members in Attendance

These are questions that were submitted by the attendees during the three day course of instruction. The questions are organized according to general JCAHO questions, Shared Visions – New Pathways, General Ambulatory questions and the Ambulatory Accreditation Manual chapters. When the questions were similar, they were grouped together to limit the length of the document.

As with any information being provided, it can change over time. It is important to check the most current edition of the applicable JCAHO standards and the JCAHO Web Site under Frequently Asked Questions (FAQs) for updates. All of the questions and answers have been reviewed by the JCAHO Standards Interpretation Group (SIG).

General JCAHO Questions:

1. *Does JCAHO have any aggregate data that is statistically significant showing a positive link between accreditation and improved patient outcomes or a decrease in patient harm?*
2. *The mission statement per the JCAHO is to "improve safety and quality of care". How is it determined that through accreditation that you are being successful in your mission? I have seen no data and am aware of none, that accreditation actually decreases patient morbidity and mortality and outcomes. Actually I am aware of data suggesting there is no difference.*

   Although there is no "statistically significant" data which links accreditation to improved patient outcomes, the JCAHO is collecting information through various sources such as ORYX, Core Measures, the OQM, etc. There is common belief that the following are just a few of the benefits of JCAHO accreditation:

   - Leads to improved patient care.
   - Demonstrates the organization's commitment to safety and quality.
   - Offers a consultative and educational experience.
   - Supports and enhances safety and quality improvement efforts.
   - Strengthens and supports recruitment and retention efforts.
   - May substitute for federal certification surveys for Medicare and Medicaid.
   - Helps secure managed care contracts.
   - Facilitates the organization's business strategies.
   - Provides a competitive advantage.
   - Enhances the organization's image to the public, purchasers and payers.
   - Fulfills licensure requirements in many states.
   - Recognized by insurers and other third parties.
   - Strengthens community confidence.

3. What is the relationship between JCAHO and the College of American Pathology? We recently passed CAP survey and were told by CAP that if we have CAP accreditation, JCAHO will not look at the lab. Is this true?

   The JCAHO and CAP do have a relationship, which recognizes certain components of the CAP survey. The JCAHO recognizes CAP accreditation for a substantial part of

the JCAHO accreditation process. However, during the JCAHO survey, the lab will be included in various aspects of the survey process, including the building tour, Point of Care testing. leadership, PI, safety, etc. which are not covered by CAP.

4. I am confused about how some standards are scored. For example, RI.1.1 (patient's right to needed services) can only be scored as a 1 (yes) or 5 (no). How can a facility score a 2, 3, or 4?

   Some standards have scoring guidelines that have only two options, yes or No. However, as a surveyor, if we are faced with information that leads us to conclude that those two options are not fully reflective of the organization's compliance, we can "flag" the score and suggest another score. This does not happen with any frequency and any "overrides" must be accompanied with a full explanation that is reviewed at Central Office.

5. How has passage of the surveyor's certification exam been validated? Passage of the exam does not mean competence (up to 20% wrong) without a validated exam?

   The Certification Exam was the first step in a series of activities that are designed to validate the competence of the JCAHO surveyor cadre. A written exam measures one component of competence and that is knowledge. Each surveyor that took and passed the exam has demonstrated their knowledge of the critical components of JCAHO and surveying. Additional activities that are designed to validate skill and critical thinking are being planned for the future. The Associate Directors, who are the managers over the surveyors, are accompanying surveyors into the field to observe the actual skills of the surveyors while on site. In addition, there are numerous distance-learning modules, which are mandatory components of continued competence that JCAHO schedules throughout the year. Additionally, feedback is given to each and every surveyor, through aggregated CEO exit data, which assists in evaluating the skills of the surveyors.

Ambulatory Program Specific Questions:

1. The Ambulatory Manual does not require NPDB query as part of the credentialing process. With the plethora of safety issues in these areas in the past few years, has JCAHO considered changing this?

   Each and every accreditation program and the standards are being reviewed to evaluate the consistency of the standards across programs. While accessing the NPDB is not currently part of the credentialing process within Ambulatory Accreditation, it will be included in this comprehensive review process. Accessing the NPDB is part of the Long Term Care program.

2. We are a freestanding Ambulatory Care Clinic with a Behavioral Health Clinic. What standards are they surveyed under?

   Both the Ambulatory Care Standards and Behavioral Health Standards will be used in the survey process, as applicable to the organization's application. NOTE: The current Ambulatory Care Standards Manual does not include behavioral health

standards. Thus, when an ambulatory care site has a behavioral health component such as an addictions program the survey is tailored to include a behavioral health surveyor and the JCAHO Behavioral Health standards are used for the survey. NOTE: There is a good resource manual available at JCAHO entitled "The Most Frequently Used Standards For Behavioral Health Care Services" for tailored or extension surveys.

3. If the corporate headquarters (MEDCOM) has a policy for a given standard or requirement, do we have to copy the entire regulation or just document specific changes that apply to the unique location?

   If specific standards require a policy and procedure for compliance to the standard, it is important for the organization to present the entire "picture" to the surveyors. Therefore, it would be better to have the MEDCOM policy available, along with any organization specific modifications to that policy / regulation, to demonstrate compliance. You need not rewrite the corporate policy as your own.

4. Are specialty clinics considered treatment sites (pulmonary, GI) or ambulatory care sites? How is the determination made between ambulatory care sites vs. treatment site?

   We do not differentiate between "treatment" sites or "ambulatory" sites. Wherever care is provided, as defined by your organization (with the exception of "combat" sites), they are included in the survey process.

5. Will the staffing effectiveness indicators be required for ambulatory clinics?

   In 2003, staffing effectiveness indicators are not required for ambulatory clinics.

6. Core measures of surgical procedures and complications – will this apply to facilities, which do outpatient (same-day surgery) and are not at a hospital?

   Core measures are currently only applicable to the hospital setting.

7. Please follow-up on the "minimal outpatient volume" (in relationship to the 1 surveyor/3 day survey). Is there a specific number of outpatient visits per day that defines this?

   If a facility has an ADC of less than 26 but has greater than 100,000 outpatient visits annually, will this still trigger an ambulatory surveyor?

   In 2002, minimal outpatient volume was defined as less than 100,000 visits per year. For 2003, the minimal outpatient volume will be defined as 125,000 visits per year. As with a determination of the survey length, complement of surveyors, etc. it is dependent on the information found within the application.

   "Minimal outpatient volumes" for 2002 is greater than 100,000 outpatient visits. For 2003, that volume increases to greater than 125,000 outpatient visits.

8. As a remote ambulatory health clinic, approximately 160 miles from our parent organization, we send specialty care to TRICARE network providers. Would you trace our "progress" through our system from their initial entry at our ambulatory clinic to the TRICARE network providers and then back to our ambulatory clinic?

   An important aspect of the "continuum of care" is how an organization coordinates care as well as communicates with ANY provider, which is treating a patient. During the survey process, any "contracted" service is included in the survey by looking at the criteria that defined what setting the patient will receive care, how information is shared/transferred among providers, how care is managed when more than one provider is involved in the care, is the patient being cared for at the appropriate level, etc. During 2003, patients are not "traced" through an organization.

Shared Visions – New Pathways:

1. "Tracer" methodology will be implemented in 2004 – will surveyors have the option to use / test this during 2003 surveys? Can facilities expect surveyors to use other 2004 changes in 2003?

   No, the "tracer" methodology will not be used in 2003.

2. Do you have suggestions for organizations that wish to use tracer methodology to do medical record review function?

   Although organizations are welcome to "trace" a patient through an encounter at an organization, that may be a cumbersome activity for all medical record review. It is an activity, however, that may be useful for one or two record reviews where there have been identified problems, but not for the entire medical record review function.

3. Depending on who is being surveyed (i.e. Command Hospital, Med Center, VA hospital), how is CC evaluated?

   a. Patient admitted to local hospital
   b. Transferred by ambulance to the medical center
   c. Transferred to VA Hospital for Long Term Rehab

   Each of the standards, which make up the Continuum of Care chapter, is used for the evaluation of the patient at different points of time.

   a) When the patient is admitted to the local hospital, the standards, which make up the activities for "Before Admission" and "During Admission", are used to evaluate the appropriateness of the admission as well as communication.
   b) When the patient is transferred to another setting, the standards, which address referral, transfer and discharge, are used to evaluate communication.
   c) When another transfer occurs, the same transfer standards are used.

   Depending on which of the above organizations is undergoing the survey will determine the scope of the survey process.

4. If “custom” manuals for surveys conducted using the Shared Visions/New Pathways methodology will be based on our application, which is done only 6 months prior to survey, does that mean we will only know for sure what standards apply to us less than 6 months prior to survey?

   Organizations should already know the types of services being provided (i.e. inpatient, outpatient, lab, etc.) by their organization. The “custom” manuals will be based on those services and as such, should not be a surprise to any organization. The “custom” manuals will be designed to only list those standards that are applicable to the organization, based on the application.

5. How does the self-assessment tool help the HCO maintain continual readiness if it’s only available 21 months of the 36 moths cycle? The current JC plan will require HCO’s to perform duplicate data entry to document compliance during 15 months immediately following survey, then transfer it to JC self-assessment tool.

   The self-assessment tool (Organization Self Assessment) (OSA) will be used to not only evaluate an organization’s compliance to the standards in anticipation of a survey, but used as an ongoing tool to continually evaluate readiness. While it is planned to only be sent to JCAHO once (at the 18-month period), it can and should be used/updated by the organization on an ongoing basis. If the organization has appropriately maintained this tool from the time of acceptance by JCAHO of the Plan for Improvement (PFI) at the 18 month mark up to the date of the actual survey at the 36 month mark there should be no major findings.

6. Why can’t the self-assessment tool be available to all HCO’s all the time?

   The OSA will be available in two versions. One version will be available at the 18-month period (free of charge) as a result of the upcoming triennial survey. Another version will be available (at a cost), which will enable organizations to use the tool as a planning document, validation document, tracking document, etc. I understand that MEDCOM plans to purchase that version when it become available, possibly September 2003.

7. As currently planned, the self-assessment tool appears to be a tool beneficial to JCAHO, not the HCO being surveyed?

   The OSA is really a tool that was designed with the HCO is mind. Often times, organizations “ramp” up in preparation for their survey. The tool is designed to assist organizations to identify their “issues” with processes, which will then focus their efforts on improvement as well as maintenance. The use of the OSA by JCAHO is to focus the efforts of the surveyors to provide a better survey process. The feedback from the pilot testing hospitals has been very positive. In addition there should be a tremendous cost savings to the HCO in that they will no longer need to hire outside consultants to assist them with survey readiness. If the OSA is used effectively the HCO will always be prepared for survey.

8. The processes captured and scored by the 18-month assessment are constantly progressing/evolving/contracting, especially among wide-ranging services across the

HCO. How will the 18-month report be reconciled with "today" at the time of the survey?

At the current time, the evaluation and validation of the OSA will be part of the triennial survey. There will be time built into the survey schedule to use the OSA, but only to validate the organization has implemented the corrective actions planned. That process is currently being developed and tested.

9. Will there be a requirement to conduct a self-assessment in 2003 for surveys in 2004? (i.e. April 2004).

   No.

10. Will facilities have to purchase the self-assessment tool?

    The OSA that will be used by organizations in conducting the assessment in preparation for the survey will be provided by the JCAHO at no charge. There will be another version of an OSA, that organizations can purchase (through JCR) that will be an "expanded" version with more capabilities and uses, such as tracking compliance, etc. I understand that MEDCOM plans to purchase one copy for each HCO.

11. How long and who determines the length of time the self-assessment should take? Any recommendations?

    There is no set time limit on how long it should take an organization to complete a OSA. The length of time an organization takes to complete a OSA is a direct function of many factors, including how many individuals participate in the review and completing, the complexity of the organization and its services and the depth of review to name a few. Organizations can choose to have one individual complete the OSA, have "teams" to complete or a combination.

12. If an organization identifies a deficiency at 18 months, develops and implements an approved plan, but 18 months later, performance has not improved (plan failed), how will standard be scored?

    The survey process involving the OSA is currently being developed and pilot tested at this time. It is anticipated that if the organization identifies the issue and has a plan for correcting the issue, then the standard related to that issue would not receive a recommendation at the time of survey. However, it the corrective action plan was not implemented and the issue is still present, a recommendation would be made.

13. Will the OSA have the PFP automated algorithms available for the facility to review?

    The PFP automated algorithms are internal to the JCAHO and will not be available for organizations to review.

14. Will there only be 3 accreditation categories after January 2004? Will Provisional and Conditional Accreditation go away?

    At the current time, it is anticipated that the accreditation categories will be:

1. Accredited – Full compliance with the standards
2. Accreditation Pending – Outstanding issues after 30 days; found while on site
3. Conditional Accreditation
4. Preliminary Denial of Accreditation
5. Not Accredited

RIGHTS AND ETHICS:

1. If a patient has an advance directive stating he does not want to be sustained on a mechanical ventilator and does not want to receive tube feedings to sustain life; however, the patient goes to the OR then experiences post-operative complications, remains on ventilator for greater than 2 weeks with numerous returns to the OR for complications with his spouse's consent. The questions is: Is it ethically correct to supercede the patient's advance directive once the patient becomes unable to verbalize his wishes and his spouse becomes the patient's main spokesperson? Is it considered a form of "battery" to go against the patient's advance directive? Where is the line drawn?

   This is an issue, which should be addressed by the organization's process for handling ethical issues arising in patient care. In some states, it has been successfully prosecuted as "battery". That is an individual state or Federal issue for the military. The line is not drawn by JCAHO standards, but rather the HCO's policies and procedures for Advance Directives, the process for handling ethical issues as well as state law. One suggestion is to direct this type of question to the legal counsel of your HCO.

2. What is the JCAHO position on obtaining Advance Directives in an ambulatory setting? Can the medical staff and governing body determine that Advance Directives will not be obtained in ambulatory setting?

   The standard, which addresses Advance Directives in an outpatient setting, is RI.1.2.5 (hospital) and RI.1.2.6 (ambulatory). Both have the same intent. It is up to the HCO to determine if you will or will not honor a patient's advance directive. The process or mechanism that an ambulatory HCO chooses is very specific to the mission and philosophy of the organization. Again, this is an issue, which may have an ethical impact; given that most organization's state they will honor the rights of the patient. In addition, the HCO must consider how they will assist the patient to formulate an Advance Directive, if they request. If the HCO will not honor them, what will be the mechanism to handle any issues that may arise.

3. Does version (attempt to turn a breech fetus in utero) procedure require an "informed consent"?

   Basically, everything performed on a patient needs informed consent. If "version" is recognized as a procedure by the medical staff, then an "informed" consent, as defined by the organization, would be required. This includes the risks, benefits and alternatives.

4. What is the standard of care for documenting "informed consent" for medication therapy? (i.e. Patient informed about risks/benefits, alternatives, expected outcomes of prescription, etc.)

   While there is no "formal" mechanism for documenting "informed consent" for medication therapy, many organizations have a document, which lists the "topics" which are covered for any treatment, procedure, etc. That would include risks/benefits, alternatives, outcomes, etc. The process for documentation is up to the HCO to determine.

5. Please identify examples of mechanisms used to ensure consistent implementation of process (hospital's) for informing patients about unanticipated outcomes of care?

   Example of mechanisms that some organization's have used include:
   a. Using a form, which delineates the types of unanticipated outcomes, which then can be checked off, if realized
   b. Using a general handout, which describes the process for informing patients of unanticipated outcomes of care.
   c. Having the medical staff develop the mechanism, making it their responsibility to handle the process.
   d. Interview the staff to determine appropriate understanding and compliance.

   Remember, the JCAHO standards do not require documentation of the implementation of the process, however your newly revised AR 40-68 does require documentation in general terms.

6. How do you manage patient privacy in the ED with curtain separation? What is JCAHO looking for?
   Organizations must use reasonable efforts to maintain patient privacy in the ED. Although curtains can provide some visual privacy, it is often the auditory privacy that is difficult to maintain. JCAHO is looking for efforts to diminish the possibility of negatively impacting patient privacy. For instance, if a surveyor were to ask an ED staff member how they maintain privacy, one might state that they lower their voices in order to reduce breaks in auditory privacy. Another example would be to not discuss "extra sensitive" issues within the area but take the family members, etc. to another location for privacy. JCAHO expects reasonable efforts. If staff state there is nothing they can do, that could be problematic.

7. Our standard is some type of anesthesia for labor and delivery. This is unheard of in most "host" nations. How does this square with pain management, standard of care, rights, etc?

   The standards require that pain be assessed and managed as a right of patients as well as a standard of care. If your practice includes anesthesia for L & D, there should be no issue, if that practice is followed. If it cannot be followed because of the practice of the "host" nations, a question might be, what can you do differently to augment the L & D, while addressing pain management. What alternatives are available?

ASSESSMENT:

1. Does a specialty clinic such as optometry, need to do the pain assessment?

   The organization determines the type of pain assessments, as applicable to the care and service being considered for the patient. An acceptable pain assessment in the optometry patient might be to simply ask, do you have pain involving the eyes. If not, that may be the extent of the assessment. Pain assessment is determined by the organization and the additional, in-depth assessments to be conducted, if the patient does have identified pain.

2. Could you specifically address requirements for triage assessment of patients? Specifically, must a Registered Nurse perform all triage? For example, can medics perform triage if a portion of or all of the records are reviewed, by a provider? Perhaps the provider could review all patients that are triaged to an appointment later that day, the next day or to home care? As I understand it, the answer here would depend on whether the location of triage employs a registered nurse. For example, our troop medical clinics would likely not employ a registered nurse whereas our outpatient clinics or emergency rooms would likely employ registered nurses.

   The type of assessment performed by each and every discipline is to be determined by the organization and should be based, in part, on the competence of the discipline to perform that assessment as well as the scope of the discipline's license. There is no requirement that an RN perform the entire triage assessment. The medics, as determined by HCO policy and procedure, may perform whatever aspects of the triage as deemed necessary per the HCO. Again, a question might be, are the medics competent to perform the assessment.

3. Why has JCAHO chosen 'pain' as a standard in as much depth as they have as opposed to heart rate assessment or blood pressure assessment, treatment and education? Is there some known history or trends or poor outcomes that drove this standard?

   There has been a great deal of information published as to the lack of effective pain management in the United States. The lack of effective pain management is the number one fear of patients that are admitted into the hospital. Because of extensive research conducted by many medical centers, it is an issue that has finally been given the attention that it needs.

4. In a managed care system, in which enrolled patients are screened on an annual basis (for nutritional and functional issues) in primary care, is it necessary to repeat the screen any time that the patient either a) seeks an appointment, or b) is referred to specialty care within the same managed care system?

   The HCO determines how nutrition and functional issues are identified. If performing a nutritional and functional screen on an annual basis is acceptable, then that process is sufficient. It need not be repeated, unless it is determined during a specific appointment or specialty visit, to be an issue, i.e., the assessment should be appropriate to the reasons they are presenting for care or service.

5. An Army Mental Health Consultant recently informed a hospital that an Active Duty Soldier could have a mental health assessment by a mental health tech if a

credentialed mental health providers isn't available? Isn't this a double standard? Especially when suicide rates and other mental health incidents are on the rise?

The HCO determines, based on organizational policy and applicable law and regulations (both Army and state) whether a mental health technician can conduct a mental health assessment. It is determined on an organization-specific basis. However, the HCO should determine the competency of a mental health technician to perform a mental health assessment, if there are concerns about one's ability to recognize problems, given the suicide rates and mental health incidents. Policy should also determine when a referral for further assessment by a credentialed mental health provider is required. There are current Army policies that address all aspects of mental health evaluations that should be followed.

CARE OF PATIENTS:

1. In the absence of a pharmacist (remote ambulatory location) what is required to allow a pharmacy tech dispense a valid prescription for a physician extended (i.e. PA, NP), when there is no physician on site?

   A pharmacy technician cannot perform anything for which they are not licensed and/or competent to do. In many states, a pharmacy tech cannot dispense, however, in the AMEDD the may dispense prepackaged medication IAW AR 40-3. Check with state and Army regulations to determine the scope of a pharmacy technicians' job. In the absence of a pharmacist and physician, what can a PA and NP do? (i.e. write scripts). Federal supremacy allows for scope of practice in DoD facilities that may vary somewhat from that of the civilian sector. The provider who is appropriately privileged may function within the framework of those clinical privileges (see AR 40-68 revision). Law and regulation should always guide the decision.

   In addition, the JCAHO Standards Interpretation Group (SIG) provided the following guidance about 2 years ago regarding DoD pharmacy technicians:
   - DoD pharmacy technicians may dispense medications entered by a physician into the CHCS system. DoD has created a technician training program and assessed the competency of the technician staff.
   - DoD pharmacy technicians may be required to dispense medications written by a physician in the community. The technician is expected to enter the medication order into the CHCS system. If an interaction message is displayed at a 1- or 2- severity level, the technician must speak with the prescriber. Additionally, if the prescriber chooses to proceed, the on call pharmacist must be contacted by the pharmacy technician to obtain authorization.
   - Medication orders input by the DoD pharmacy technician must be reviewed by the DoD pharmacist when next on duty. This will include a review of all new medication orders, all changed medication orders, and all lower level overrides that may have been authorized by the physician.

2. Are physicians, NP's, PA's required to be credentialed to dispense? Many ER's use nurses to dispense prescription medications after pharmacy hours (remote / rural locations). Do they need to be specifically credentialed?

Physicians do not require specific privileges for dispensing medications they have prescribed to their patients. IAW AR 40-68 and AR 40-3, NP's and PA's, as well as other non-physician providers are privileged to write for, and may dispense, medications (see AR 40-3, chapter 11). Nurses functioning in EC settings during hours the pharmacy is closed may dispense prepackaged, prescription medications, however, these must verified by the prescribing provider prior to the patient leaving the treatment area. OTC medications may be dispensed IAW local policy for "self-care programs". Again, Federal supremacy allows for a scope of practice that is somewhat less restrictive than the civilian sector.

3. Our NICU wants to develop a code sheet specific for their unit. Can they do so as long as they meet JCAHO and facility as well as AAP and NRP?

   Yes, there is nothing in the JCAHO standards that would prohibit a code sheet for NICU.

4. Our addition treatment facility will be relocating. Should it be housed outside the main hospital, does it have to conform to the JCAHO standards as the main facility?

   The answer is yes if the treatment facility is considered part of the hospital campus and depending on the type of patients served (short-stay, in-patient, outpatient) will determine which standards are applicable (especially for EC). The Hospital standards apply if they are a part of the hospital and the Behavioral Health standards if they are a part of an ambulatory health facility.

5. Would you discuss the use of short-acting anesthetic medications for procedures? (i.e propofol in colonoscopies).

   The use of any medication, (propofol) as an anesthetic, should be determined based on the pre-anesthesia assessment and plan. Its use is dependent on many factors, including age, debilitation, type of procedure, length of procedure, drug interactions, history of its use in the patient, adverse reactions, etc. FYI: One of the cautions in using this propofol is the need for strict aseptic technique during handling. Another issue is who will be using the medication, the anesthesiologist or the provider performing the procedure.

6. Is a pre-anesthesia assessment (check airway, oropharynx, and history of adverse reactions to anesthetic) necessary for all patients receiving moderate sedation (on the assumption that the patient could slip into deep sedation?

   Yes, by Standard TX.2.1, but the type of pre-anesthesia assessment is to be determined by the HCO. As a standard of practice, the assessment does include, at a minimum, the items listed.

CONTINUUM OF CARE:

1. What is the standard of ambulatory care for following up on lab tests non-compliance? Is it considered standard of care to contact patients who do not get lab tests?

The standard for follow-up of patients is to be set by the HCO itself. The practice of following-up on patients who did not get lab tests is dependent on the ambulatory care setting and organization policy.

2. What successful methods have you seen to accomplish this?

   This can be an overwhelming feat, given the numbers of patients seen in many ambulatory settings. To address this issue, most ambulatory centers set priorities on which patients need to be followed and focus their efforts on those determined to be most at risk. Using pre-established criteria, they focus their efforts on those that could have the most untoward outcome, if not followed.

LEADERSHIP:

1. Do the patient safety goals for January 2003 affect ambulatory care only to include no same day surgery?

   The National Patient Safety Goals apply to all programs in 2003. It is up to each organization to determine if each of the specific goals is applicable to the care and service it provides. If an organization performs surgery, the goals related to patient identification as well as wrong site surgery apply.

2. Can we use the FMEA (VA program) process for things that went wrong as well as things that might go wrong?

   Although an HCO can use FMEA in whatever capacity it chooses, FMEA is best used as a proactive tool, to be used prior to an event. Often times, if an FMEA is used when things went wrong, the individuals participating in the FMEA have a difficult time in thinking beyond the "event" and are stymied to think of all possible issues/outcomes. A root cause analysis, which is thorough and credible is the best activity for an event which has already occurred.

IMPROVING ORGANIZATIONAL PERFORMANCE:

1. PI activities for the hospital's leaders: One for each of the seven areas (plans). Does this mean a total of one (1) for EC (EC.4.2)?

   Each of the seven EOC plans must be monitored. Those results should result in recommendations for changes and performance improvement suggestions, which then are communicated to the leadership. It may include more than one, if the monitored results demonstrate the need. From those results, the leaders are to consider one or more areas that are to be addressed by PI activities.

2. Uniform performance of patient care processes: Does this process meet standard? Daily discharge planning rounds M – F and none on the weekends. The ward nurses given a DC planning resource book in the event they need to arrange for DME, O2 etc. plus in-service provided.

   Yes, if it is appropriate to the patient's discharge needs.

3. One example of a reviewable sentinel event states, “any perinatal death unrelated to congenital condition in an infant having a birth weight greater than 2500 grams”. Does the definition of infant include a fetus that dies in utero after 37 weeks gestation? Is an IUFD of unknown reasons a reviewable event?

   The organization needs to define how that will be interpreted by the specific HCO.

ENVIRONMENT OF CARE:

1. Are the NFPA 2000 standards being used in the 2003 surveys?

   Yes, after March 1, 2003. There are minor differences between 1997 and 2000 requirements, so any existing documentation is acceptable. You will not need to “transpose” any existing documentation on the old SOC to new forms.

2. If the Emergency Management Plan addresses decontamination of bio-hazardous materials with implementation of a team and use of a station should/must this also be included in the HazMat Plan?

   The HazMat Plan should be coordinated with the Emergency Management Plan. What is more important is that the individuals responsible for each of the seven plans work together. Many of the requirements can cross over into several of the areas. It is not the intention of the JCAHO to require duplication of efforts.

3. Infant Security Requirements: Interim Site survey team from our higher headquarters recommends we implement one security measure (either cameras / limited access / tags on babies). We have strong abduction policy in place, staff orientation and continuing education. Every new equipment initiative, which costs money, is highly scrutinized due to a new hospital in 5 years. Do we need monitored doors with limited access cards?

   The actions that an organization takes should be based, in part, on information contained in the Sentinel Event Alert # 9, April 9, 1999. The root causes and the suggested strategies are proven to reduce the risk of infant abduction. As always, cost is an issue, which must be addressed. At survey time, questions regarding the use of suggested strategies listed in the Sentinel Event may be raised.

   Root Causes Identified

   All the hospitals identified unmonitored elevator or stairwell access to the postpartum and nursery areas as a root cause. Root causes fell into the following six general areas:

   - Security equipment factors such as security equipment not being available, operational or used as intended.
   - Physical environmental factors such as no line-of sight to entry points as well as unmonitored elevator or stairwell access.
   - Inadequate patient education.

- Staff-related factors such as insufficient orientation/training, competency/credentialing issues and insufficient staffing levels.
- Information-related factors such as birth information published in local newspapers, delay in notifying security when an abduction was suspected, improper communication of relevant information among caregivers, and improper communication between hospital units.
- Organization cultural factors such as reluctance to confront unidentified visitors/providers.

Suggested Strategies for Reducing Risk

The Joint Commission suggests that hospitals consider the following actions:

- Develop and implement a proactive infant abduction prevention plan.
- Include information on visitor/provider identification as well as identification of potential abductors/abduction situations (during staff orientation and in-service curriculum programs).
- Enhance parent education concerning abduction risks and parent responsibility for reducing risk and then assess the parents' level of understanding.
- Attach secure identically numbered bands to the baby (wrist and ankle bands), mother, and father or significant other immediately after birth.
- Footprint the baby, take a color photograph of the baby and record the baby's physical examination within two hours of birth.
- Require staff to wear up-to-date, conspicuous, color photograph identification badges.
- Discontinue publication of birth notices in local newspapers.
- Consider options for controlling access to nursery/postpartum unit such as swipe-card locks, keypad locks, entry point alarms or video surveillance (any locking systems must comply with fire codes).
- Consider implementing an infant security tag or abduction alarm system.

Note: In principle, Engineering Controls (i.e. locks, tags, etc.) are more reliable – and therefore preferred to relying solely on staff response (and "administrative control"). Your economic analysis should also consider on-going operational cost of providing 24/7 staffing of a controlled area versus the cost of security systems.

4. In an outpatient clinic, is a risk analysis required if a construction project will be completed on the weekend?

   The outpatient clinic, when hospital based, should perform a risk analysis using risk criteria to identify hazards when they impact areas where patient care is impacted. If the construction will be started and completed when there is is no patient care being performed, then it may not be necessary. The HCO should always examine the impact (both short term and long term) on air quality, utility, infection control. Noise, vibration and emergency procedures would not be factors to be considered.

5. Security of Sharps: What is the requirement for maintaining security for sharps (i.e. needles, knife blades)? Are two locks required versus locked cabinet in a room with closed door?

The standards require sharps to be secured. This does not always include locking the sharps. Security can often be maintained, depending on where the sharps are being stored, by where they are stored. If they are stored in a room behind a nurses' station, accessed by select employees, then that may be enough. If they are stored in high traffic areas, where they are not continually monitored, then locks may be required. The locking of sharps is always depending on the location of storage, the continual monitoring by individuals working and who has access to the location. OSHA regulations should always be utilized in the development of any procedures for security.

MANAGEMENT OF HUMAN RESOURCES:

1. We have a need for medics (EMT – B) level of training to perform on-site triage using menu driven algorithms. How do we certify these medics in order to use them in a military hospital?

   The HCO should determine the qualifications for medics as well as any application law/regulations. Based on those qualifications, an HCO may determine what, if any certification (or documented competency based orientation) is needed. It is an individual decision by the HCO; there are no standards, which require a certification.

2. We are contemplating recovering our C-Section patients in L & D. Currently they go to recovery room in PACU or ICU after hours. If all ICU and PACU nurses requirements includes having ACLS, do all my L & D nurses need ACLS before I can recover patients or can I require just attendance at in-services on recognition of arrhythmias and management of post-op patients?

   As an HCO, you determine the qualifications in recovering patients, depending on the area, the types of patients, anesthesia, etc. As an organization you must ensure a uniform quality of care. Questions to consider include, do the L& D nurses need to have the same qualifications, if they are not recovering the same types of patients. It may be enough to attend in-services. If they are recovering the same type of patients, then equivalent competence would be required. One caution, however. Attending in-services do not necessarily mean an individual is competent.

3. If state practice law prohibits UAP from giving medications but military facility allows UAP following competency training / assessment, to give meds, how will this be looked at by JCAHO?

   An organization should always follow law and regulation, if that is determined to be the guiding factor. If state practice act allows a UAP to give medications, then the HCO should determine the qualifications of the UAP, what specific medications will be given, under what circumstances, with what training and competency testing, etc. In light of Federal supremacy, guidance at the Army level (e.g., AR, MEDCOM policy) will stipulate what medications, if any, the qualified UAP may be authorized to administer.

   There are specific standards which state HCO will comply with law and regulation. If an HCO doesn't, that could be problematic.

4. How long do I need to keep documentation for competency assessment? How many years back do we have to keep documentation in files? Some have documentation 5 – 10 years back.

   This question has two answers. First, for JCAHO surveys, documentation should be kept for at least a three-year period (from survey to survey). However, information, which demonstrates competency of staff, may be useful in case of lawsuits, which may have a longer statute of limitations. Check with your HCO's legal counsel to determine how long your HCO should maintain information for personnel purposes.

5. Do volunteers need annual performance evaluations?

   Yes, based on their job responsibilities. There is a specific FAQ on the JCAHO's website regarding volunteers.

6. Do students have to receive the same comprehensive training, etc. that the hospital staff receives?

   Students must receive an orientation to patient care, safety, infection control and other designated topics, per the HCO. It does not have to be exactly the same; however, it should be comparable in those areas, which are most important, as determined by the HCO. This issue needs to be addressed in the contract with the school.

7. Do we need to identify all areas of the hospital for the staffing effectiveness or can we limit the HR and C/S measures to a smaller group? For instance, direct caregivers only for inpatient nursing, lab, RT and pharmacy?

   At the current time, the staffing effectiveness indicators should address all inpatient populations. This includes all clinical areas and only non-clinical areas as appropriate to the indicator. The HCO can determine which indicators are reflective of the populations served. For instance, the C/S indicators of medication errors and patient satisfaction might apply to all areas, including ICU's, pediatrics, etc. The HR indicators are the ones that need to include both direct and indirect caregivers, as appropriate to the indicator.

8. Should the scope of services state their staffing levels and mix?

   It is a good idea to include the staffing levels and mix in the scope of services. Refer to CC.2 and 2.1 for further guidance.

SURVIELLANCE, PREVENTION AND CONTROL OF INFECTIONS:

1. How does JCAHO look at the new CDC waterless hand washing guidelines?

   The JCAHO expects HCO's to consider and incorporate the latest scientific information into the current practices. The use of waterless hand washing solutions has been proven to be as effective as hand washing and promotes compliance with procedures.

MEDICAL STAFF:

1. We are a primary care clinic only with no medical staff executive committee. Our credentials submit their minutes to the commander. Is that okay?

   If your HCO is hospital based, then the credentialing process falls under the Medical Executive Committee and its process. For freestanding, submitting them to the commander is okay, if the Commander is considered the governing body.

2. The JCAHO FAQ stipulates that medical students are not health care providers, i.e. a LIP must perform and document an H & P, regardless of whether a medical student was involved first. Does this extend to H & P like assessments, e.g. ER visits, and specialty consults? Does this extend to other student types? Does this extend to interns, residents?

   Yes.

3. Are there any guidelines on the number of reviews an LIP must do or the number of times he/she must be reviewed, in order to be favorably considered for credentialing or re-credentialing?

   No, that is determined through the Medical Staff Bylaws and the credentialing process.

4. There is a rumor that primary source verification is required for RN's, RT's? Is that true? It is not stated in the HR standards either.

   That is a rumor. No, primary source verification is not required for RN's, RT's; however many organizations do primary source verification because it is required by some state law and regulation. Check with your state practice organizations to determine what type of verification is required.

5. Please clarify that in addition to primary source verification of various credentials (med school, licensure, post-graduate training), maintaining a copy of the document in the providers credentials file is not required?

   A copy is not required for the credentials file.

6. MS.2.4.1: What are the "governing body" bylaws and are they different from the "medical staff" bylaws?

   The medical staff bylaws direct only the activities of the medical staff within the organization. The governing body bylaws direct the governing body in all activities within the HCO, of which the medical staff is but one component.

7. What is the federal guideline on NP/PA's writing narcotics?

   The scope of practice of the NP/PA's is determined by the state, the physician and is the physician's responsibility.

8. MS.2.6: Why does JCAHO not place this same emphasis on all other medical disciplines?

The standard will be revised to read “Practitioner Health”.

9. If a military hospital provides the physician and /or other credentialed provider to a “troop medical clinic”, is this clinic surveyable? Many are not disclosed on the application due to unclear interpretation?

   Troop medical clinics are surveyable by direction of both DODHA and MEDCOM and must be declared on the application for survey. If not declared, the application for survey would be inaccurate and could be considered as falsification of information submitted. One of the conditions for survey eligibility is that all information submitted on the application must be accurate and true. It would not be a good idea to have the survey team find a program during survey, that the HCO is responsible for, and that has not been reported to JCAHO on the application.

MANAGEMENT OF INFORMATION:

1. Is a summary list / master problem list required for patients seen only in specialty clinics? They are eligible for care but not enrolled in our facility, so their PCM is not one of our providers. They may be seen on a space available basis in our specialty clinics, such as optometry only. Would the specialist be required to complete the summary list?

   A Master Problem List is required for those patients who will be seen on an ongoing basis. Often, ambulatory clinics will use one problem list by all providers in order for the primary care providers and the specialists to keep abreast of the patient’s current issues. However, the list, at a minimum, must list those areas being addressed by the primary care provider.

2. Soldiers have two places in their record where chronic medical conditions, allergies, current meds, procedures, and hospitalizations are to be documented. Can documentation on one state, “see the other form”? Is filling out just one a no go?

   As long as the one list is complete, then the second one is not necessary.

3. We are researching CIS for electronic documentation. What’s JCAHO opinion or acceptance of CIS for electronic records? How does CIS compare to written documentation (paper) in effectiveness, neatness and JCAHO approval?

   CIS can be used for some, if not all of the documentation, depending on how it is developed, used and available for used during the survey. JCAHO does not have an opinion. How an HCO uses its electronic record is more the issue. The IM standards apply to any documentation, whether manual or electronic. As always, electronic records are usually neater. During the survey, make sure the surveyors know what are the components of the medical records, which are electronic and have them, available during the survey. In addition, you must ensure that you are also in compliance with all Army directives pertaining to this area.

4. For a strictly primary care clinic, does the SF 600 have to have a time of the actual visit or is the computer print out of appointment time enough?

Yes

5. We utilize automated order and reporting mechanism “CHCS” for lab/radiology/pharmacy documentation. We utilize this as an extension of the medical record. In most instances, we do not print out and place in our outpatient records. Is this acceptable to use the CHCS system as an extension of the medical record?

   Yes, if it is defined in policy, procedure and regulations, can be accessed rapidly by all staff that require access to the total medical record and can be demonstrated to the JCAHO survey team.

6. Re: HIPAA: Do HIPAA rules require patient written consent in order for abstractors to conduct ORYX and core measure data?

   Yes, patients must consent for “outsiders” to access their records however I understand that DOD is in the process of adding comments to the abstractor contract that will satisfy this requirement.

7. If a medical record is unable to stand alone, (i.e., inappropriate medication for treatment of the diagnosed condition) does the reviewer place a note in the chart (possible future liability) or is documentation kept in a separate file, or is it the hospital’s responsibility to set the standard for the facility?

   The JCAHO standards do not address this issue. However, in practice, risk managers as well as anyone connected with liability claims would never advocate adding a note, highlighting an inappropriate action taken. Usually, issues such as the one raised are considered Unusual Occurrences and as such, have separate documentation, which is kept as part of incident reporting and tracking. There should never be a note that an “Incident Report” has been completed in the patient’s medical record.

8. Please comment on the issue of legibility in medical record documentation. How do you judge legibility?

   Legibility is very subjective. However, while on survey, if 2 or 3 individuals who work with the provider in question, is unable to read the medical record documentation, then legibility may be questioned.
   END OF QUESTIONS: